 **PATIENT INFORMATION**

4246 Electric Rd. Roanoke, VA. 24018
**Phone:** (540) 904-7823 | **Fax:** (540) 904-7826
[**www.footcompanion.com**](http://www.footcompanion.com) **| info@footcompanion.com**

 ***For Office Use Only***

 **Patient Information:**

**Name:**

 (LAST) (FIRST) (MIDDLE INITIAL)

**Address:**

 **Home Phone: Work Phone: E-Mail:**

**Date of Birth: / /**

**Gender: Male Female Social Security #**

**Patient Status: Single**

**Married Other**

**Occupation:**

 **Employer's Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Employer's Address: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (Name) (Address) (Phone) **Health Information:**

**Height: Weight: Diabetic: Yes No**

**If Diabetic, name of physician treating your condition:**

**Amputations: Dates of Amputation: Reason: Surgeries related to your visit: Other medical professionals you have seen relating to your visit:**

 **Responsible Party:**
 **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Home Phone:**

**Work Phone:**

**Date of Birth: / /**

**Gender: Male Female Social Security #:**

**Relationship to Patient: Employer's Address:**

 **Primary Insurance Information:**

**Insurance Company Name: Policy ID#: Address: Group #: City: State: Zip: Phone: Policy Holder: DOB: Relationship:**

 **Secondary Insurance Information:**

**Insurance Company Name: Policy ID#: Address: Group #: Policy Holder: DOB: Relationship**

**Patient Signature:**

I verify the accuracy of the above information. We cannot render services on the assumption that the charges will be paid by insurance company.

I have read and understand that Foot Companion, Inc. may bill the insurance company, but this DOES NOT GUARANTEE BENEFITS. I understand that Foot Companion, Inc. will bill me directly for all supplies and services not covered by the insurance company. I understand that these supplies are not returnable once I have removed them from the premises.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PATIENT OR AUTHORIZED SIGNATURE)